

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1906 CERTIFICATE OF DEATH

01899

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CHARLES</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>ST. MARY'S</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>	LENGTH OF STAY (in this place) <u>4 WEEK'S</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MECHANICSVILLE 18X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>RONALD CRAIG BURROUGHS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 18 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE-US</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JANUARY 21, 1960</u>
9. AGE last birthday — yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>28</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>US.</u>			
13. FATHER'S NAME <u>LUTHER KENNETH BURROUGHS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA P. LONG.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>L. KENNETH BURROUGHS</u> <u>MECHANICSVILLE, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
1. IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>			<u>4 HOURS</u>
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>PREMATURITY (6 1/2 mos Gestation)</u>			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>60</u> , to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>60</u> , and that death occurred at <u>1:15 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>John H. Griffin</u> M.D.		ADDRESS (Street, city, town, state) <u>Mechanicsville, Md.</u>	
DATE SIGNED <u>2/19/60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/20/60</u>	NAME OF CEMETERY OR CREMATORY <u>All Faith Cemetery</u>	LOCATION (City, town, or county) (State) <u>Charlotte Hall, Md.</u>
24. REC'D BY REGISTRAR <u>FEB 24 1960</u>	REGISTRAR'S SIGNATURE <u>—</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Maryland</u>	

2266295XVI

DEATH CERTIFICATE OF DEATH

THIS FORM IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

1. Name of deceased (Print name in full)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of birth (Month, Day, Year)

5. Place of birth (City, State, Country)

6. Usual residence (Street, City, State, Country)

7. Date of death (Month, Day, Year)

8. Time of death (Hour, Minute)

9. Cause of death (Immediate cause)

10. Cause of death (Underlying cause)

11. Cause of death (Contributing cause)

12. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

13. Signature of physician or other person having knowledge of cause of death

14. Signature of registrar or other official

15. Signature of witness

16. Signature of witness

17. Signature of witness

18. Signature of witness

19. Signature of witness

20. Signature of witness

21. Signature of witness

22. Signature of witness

23. Signature of witness

24. Signature of witness

25. Signature of witness

26. Signature of witness

27. Signature of witness

28. Signature of witness

29. Signature of witness

30. Signature of witness

31. Name of deceased (Print name in full)

32. Sex (Male or Female)

33. Age (Years and Months)

34. Date of birth (Month, Day, Year)

35. Place of birth (City, State, Country)

36. Usual residence (Street, City, State, Country)

37. Date of death (Month, Day, Year)

38. Time of death (Hour, Minute)

39. Cause of death (Immediate cause)

40. Cause of death (Underlying cause)

41. Cause of death (Contributing cause)

42. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

43. Signature of physician or other person having knowledge of cause of death

44. Signature of registrar or other official

45. Signature of witness

46. Signature of witness

47. Signature of witness

48. Signature of witness

49. Signature of witness

50. Signature of witness

51. Signature of witness

52. Signature of witness

53. Signature of witness

54. Signature of witness

55. Signature of witness

56. Signature of witness

57. Signature of witness

58. Signature of witness

59. Signature of witness

60. Signature of witness

RECEIVED
BALTIMORE
MAY 10 1912
DEPARTMENT OF HEALTH
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b X Tompkinsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians' Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Jr. Last Chisley				4. DATE OF DEATH Month 2 Day 18 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY on Farm		11. BIRTHPLACE (State or foreign country) Charles County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Chisley				14. MOTHER'S MAIDEN NAME Mary Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-12-7672		17. INFORMANT Mr. William Chisley - Brother-Tompkinsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Gangrene Lower Extremities 824X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compression of Spinal Cord DUE TO (c) Falling from moving truck				INTERVAL BETWEEN ONSET AND DEATH 10-15-'59 8-27-'59 8-27-'59			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell from moving truck							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from moving truck			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8-27-59 p. m. 		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Tompkinsville, Charles, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. J. Edelen				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. Edelen, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/1960		22c. NAME OF CEMETERY OR CREMATORY Holly Ghost Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc.				24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be cut from the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Time of Death	
Occupation		Education		Medical History		Physical Examination		Mental Examination	
Family History		Social History		Autopsy		Toxicology		Microscopic Examination	
Postmortem Examination		Disposition of Body		Burial Place		Burial Date		Burial Time	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Nurse		Signature of Witness	
Date of Certificate		Time of Certificate		Place of Certificate		State of Certificate		County of Certificate	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Physicians Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1123 - 11th. Street N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR WILLIAM FOSTER		4. DATE OF DEATH Month FEBRUARY Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1921
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 12 Min.	
11. BIRTHPLACE (State or foreign country) STOCKMAN MURPHY (STOCK)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Floyd Foster		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown) RAMEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 577-28-4183	
17. INFORMANT Address Mrs. Mildred Foster - 1123 - 11th. St. N.W., DC.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SKULL FRACTURE (RIGHT PTERIOUS BONE) (c) and COMPOUND FRACTURE LEFT TIBIA		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PEDESTRIAN - Struck by auto - 1 1/2 mi. No. WALDORF	
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 2-20 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Waldorf, Charles, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE J.B. Detton		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V.B. DETTON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/25/60	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co - WASH. D.C.		24. REC'D BY REGISTRAR DATE FEB 23 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1982

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.



1909 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) L2 Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Waldorf	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary I Gardiner		4. DATE OF DEATH Month Day Year Feb. 25 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Middleton		14. MOTHER'S MAIDEN NAME Isabelle Bowling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hugh C. Gardiner Jr, Fawltner, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 12, 1960 to 2-25, 1960 , that I last saw the deceased alive on 2-25, 1960 and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Edelen		DATE SIGNED 2-26-60	
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-60	22c. NAME OF CEMETERY OR CREMATORY St Peters	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR DATE 2-9-60	24b. REGISTRAR'S SIGNATURE Arthur S. Kross

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Date of Death: _____

7. Time of Death: _____

8. Cause of Death: _____

9. Place of Death: _____

10. Signature of Physician: _____

11. Signature of Registrar: _____

12. Signature of Coroner: _____

13. Signature of Medical Examiner: _____

14. Signature of Funeral Home: _____

15. Signature of Family: _____

16. Signature of Other: _____

17. Signature of Other: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

22. Signature of Other: _____

23. Signature of Other: _____

24. Signature of Other: _____

25. Signature of Other: _____

26. Signature of Other: _____

27. Signature of Other: _____

28. Signature of Other: _____

29. Signature of Other: _____

30. Signature of Other: _____

31. Signature of Other: _____

32. Signature of Other: _____

33. Signature of Other: _____

34. Signature of Other: _____

35. Signature of Other: _____

36. Signature of Other: _____

37. Signature of Other: _____

38. Signature of Other: _____

39. Signature of Other: _____

40. Signature of Other: _____

41. Signature of Other: _____

42. Signature of Other: _____

43. Signature of Other: _____

44. Signature of Other: _____

45. Signature of Other: _____

46. Signature of Other: _____

47. Signature of Other: _____

48. Signature of Other: _____

49. Signature of Other: _____

50. Signature of Other: _____

51. Signature of Other: _____

52. Signature of Other: _____

53. Signature of Other: _____

54. Signature of Other: _____

55. Signature of Other: _____

56. Signature of Other: _____

57. Signature of Other: _____

58. Signature of Other: _____

59. Signature of Other: _____

60. Signature of Other: _____

61. Signature of Other: _____

62. Signature of Other: _____

63. Signature of Other: _____

64. Signature of Other: _____

65. Signature of Other: _____

66. Signature of Other: _____

67. Signature of Other: _____

68. Signature of Other: _____

69. Signature of Other: _____

70. Signature of Other: _____

71. Signature of Other: _____

72. Signature of Other: _____

73. Signature of Other: _____

74. Signature of Other: _____

75. Signature of Other: _____

76. Signature of Other: _____

77. Signature of Other: _____

78. Signature of Other: _____

79. Signature of Other: _____

80. Signature of Other: _____

81. Signature of Other: _____

82. Signature of Other: _____

83. Signature of Other: _____

84. Signature of Other: _____

85. Signature of Other: _____

86. Signature of Other: _____

87. Signature of Other: _____

88. Signature of Other: _____

89. Signature of Other: _____

90. Signature of Other: _____

91. Signature of Other: _____

92. Signature of Other: _____

93. Signature of Other: _____

94. Signature of Other: _____

95. Signature of Other: _____

96. Signature of Other: _____

97. Signature of Other: _____

98. Signature of Other: _____

99. Signature of Other: _____

100. Signature of Other: _____

1910 CERTIFICATE OF DEATH

01903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN TB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First James Middle Enoch Last Garner		4. DATE OF DEATH Month Feb Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1875
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Garner	
14. MOTHER'S MAIDEN NAME Zora Rawlins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Fred Garner, Brandywine, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 442X DUE TO Chronic C.V. R. Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (c) at least 1 yr		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS GIVEN IN PART I (a) Inability to swallow due to Glaucoma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10, 1960 to 2/11/1960 , that I last saw the deceased alive on 2/10/1960 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE V.M. Seim MD		ADDRESS (Street, city or town, state) DATE SIGNED Waldorf Md 2/12/60	
PHYSICIAN'S NAME (Type) V.M. SEIM MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-60	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Waldorf, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

1910

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1875		New York, N.Y.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Coronary Artery Disease		Chest Pain, Shortness of Breath		Jan 15, 1910		New York, N.Y.	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1911 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
c. LENGTH OF STAY IN <u>Life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>G</u> Last <u>GARNER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNK, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK, Garner</u>		14. MOTHER'S MAIDEN NAME <u>Sally Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Alice Wade, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Acute Bacterial Broncho Pneumonia</u> <u>447.1</u> DUE TO (b) <u>Acute Myocardial Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Valvular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>00</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 12</u> , 19 <u>60</u> , to <u>Feb 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>60</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V.M. Seron</u>		DATE SIGNED <u>2/13/60</u>	
PRINT NAME (Type) <u>V.M. SERON MD</u>		M.D. <u>Waldorf Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Rest</u>	22d. LOCATION (City, town or county) (State) <u>La Plata, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Conrad S. Pious</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22

WILLIAM

CORNER

22

1912 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Rock Point, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eunice Marie GOOSEBERRY		4. DATE OF DEATH FEB. 6 1960	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1956
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Gooseberry		14. MOTHER'S MAIDEN NAME Helena Smathers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mr. Joseph R. Gooseberry, Rock Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-30 , 19 60 , to 2-6 , 19 60 , that I last saw the deceased alive on 2-6 , 19 60 , and that death occurred at 9:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. M. Johnson M.D.		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 2-6-60	
PHYSICIAN'S NAME (Type) F. M. JOHNSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/1960	22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery	22d. LOCATION (City, town, or county) (State) Issue, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Archart, Inc. ADDRESS Archart Funeral Home, Inc. La Plata, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22

4.



1913 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle FRANCIS Last GREENE		4. DATE OF DEATH Month 2 Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal worker		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward F. Greene		14. MOTHER'S MAIDEN NAME Mary E. Fowles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-3-1531	
17. INFORMANT Mrs. Mary E. Michael-Sister, Cobb Island Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, Pulmonary DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4-59-2-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1960 to 2-24-60 , that I last saw the deceased alive on 2-24-60 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 2-24-60			
ACTUAL SIGNATURE E. J. Edelen M.D.		PHYSICIAN'S NAME (Type) E. J. Edelen, M.D. La Plata, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/26/1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ARSHART FUNERAL HOME, INC. * LA PLATA, MD.		24a. REC'D BY REGISTRAR DATE MAR 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1914											
1. PLACE OF DEATH a. COUNTY Charles					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf					c. LENGTH OF STAY IN life Life						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS Waldorf						
3. NAME OF DECEASED (Type or print) EDWARD LEWIS HOWE					4. DATE OF DEATH Month February Day 10 Year 1960						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 4, 1959		9. AGE (In years last birthday) 4 IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Matthew Lawrence Howe					14. MOTHER'S MAIDEN NAME Ethel Marie Largen						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)					16. SOCIAL SECURITY NO. NONE					17. INFORMANT Address Matthew Lawrence Howe, Waldorf, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE William V. Lovitt, Jr.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 2/11/60	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2-12-60		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or country) (State) Bryantown, Maryland				
23. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Maryland					ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howe		

2-12-60

100
100



100 100 100 100 100 100 100 100 100 100

100 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 111-6257 2-19-60 et

1915

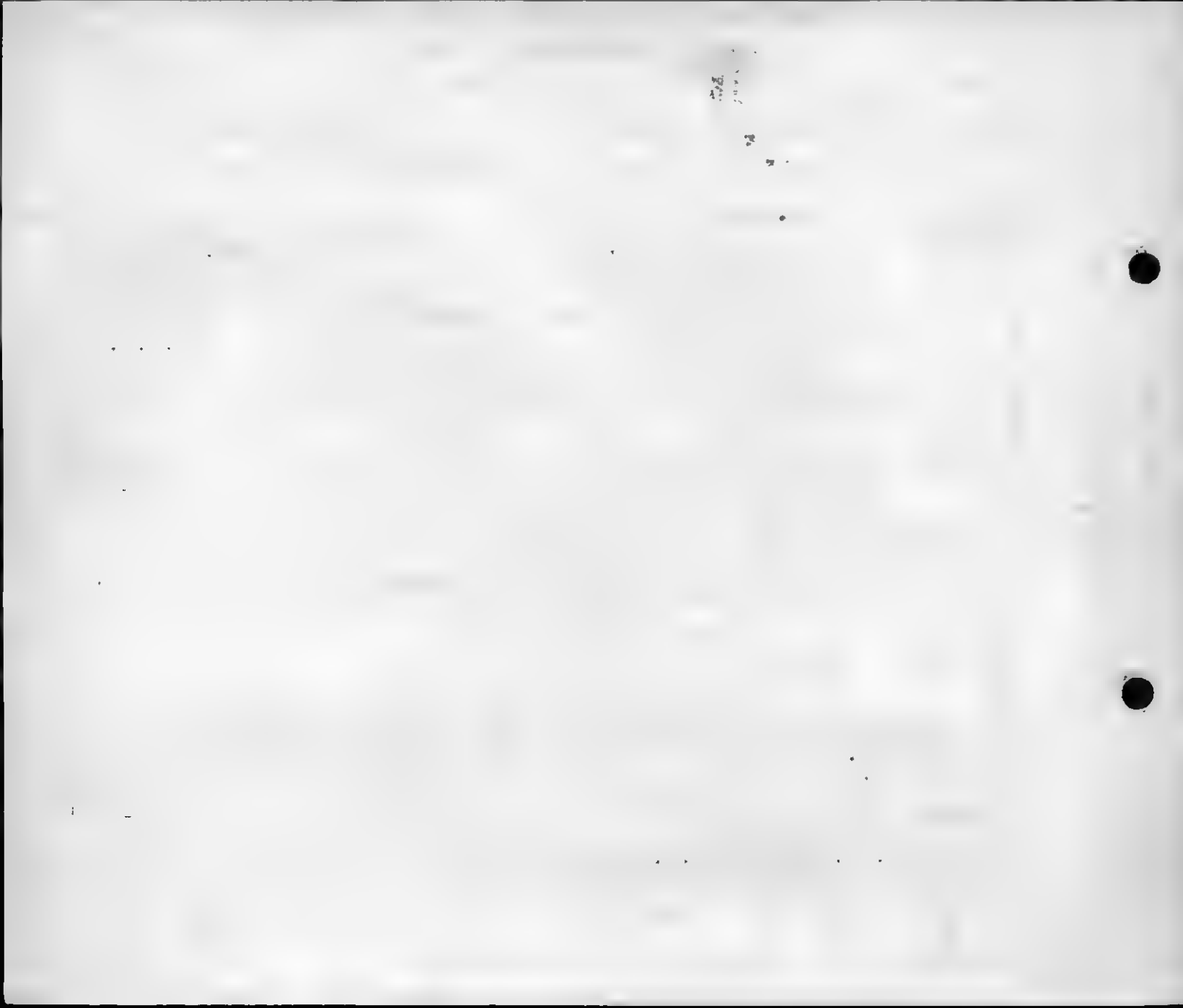
CERTIFICATE OF DEATH

Reg. Dist. No.

01908

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Leon Middle W. Last James				4. DATE OF DEATH Month Feb. Day 20 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1892	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 20 Days 20 Hours 1960		11. IF UNDER 24 HRS Months 20 Days 20 Hours 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Rochester, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick James				14. MOTHER'S MAIDEN NAME Kate Eustace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT David James Port Tobacco Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c) Cancer Larynx with Surgery						INTERVAL BETWEEN ONSET AND DEATH 2-20-'60 1950 Jan. 1960	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to 2-20 , 1960, that I last saw the deceased alive on Dec. 30 , 1960, and that death occurred at 2 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2-22-'60							
ACTUAL SIGNATURE E. J. Edelen M.D.				DATE SIGNED 2-22-'60			
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
Burial		2/23/60		Lee's		Washington Dc	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Inc Topolata Md				24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1916

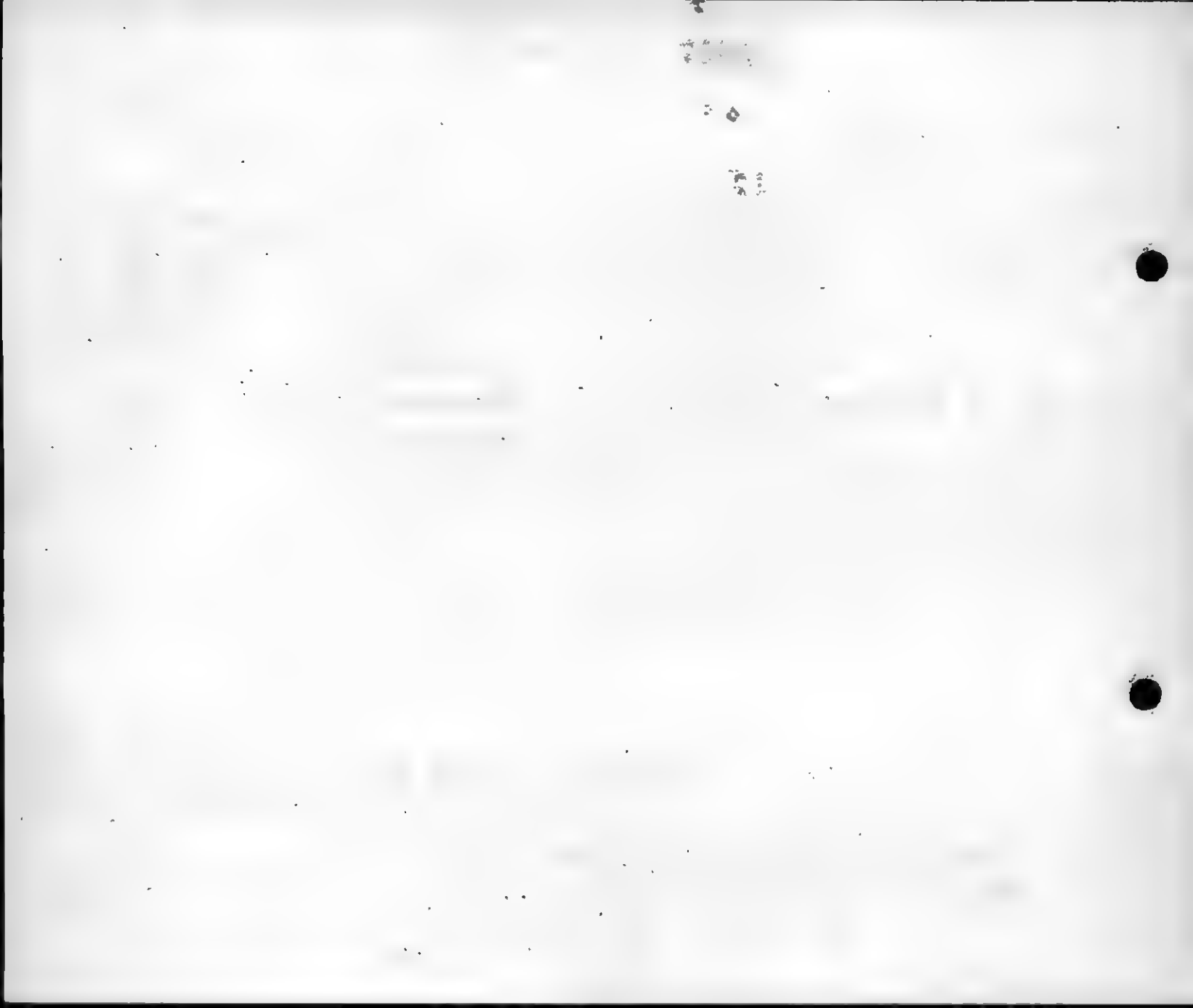
CERTIFICATE OF DEATH

Reg. Dist. No.

01909

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seplata</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seplata</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>YVETTE</u> Middle <u>MARIE</u> Last <u>JENKINS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-59</u>
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas E Jenkins</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Ruth Thomas</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas E Jenkins Seplata</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I attended the deceased from <u>1-18</u> , 19 <u>60</u> to <u>2-21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-21</u> , 19 <u>60</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>F. M. JOHNSON</u> M.D.		ADDRESS (Street, city or town, state) <u>Seplata Md.</u> DATE SIGNED <u>2-21-60</u>	
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON</u>		22a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	
22b. DATE THEREOF <u>2/21/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seplata</u>	
22d. LOCATION (City, town or county) <u>Md.</u> (State) <u></u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Seplata</u> ADDRESS <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1917 CERTIFICATE OF DEATH

01910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Lz Plata		c. LENGTH OF STAY IN 1b Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle Magdoline Last JOHNSON		4. DATE OF DEATH Month FEB Day 16 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Wise		14. MOTHER'S MAIDEN NAME Cecelia Cullison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Phillip Johnson, Rock Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 20 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-15 , 19 60 , to 2-16 , 19 60 , that I last saw the deceased alive on 2-15 , 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lz Plata, Md. DATE SIGNED 2-16-60			
ACTUAL SIGNATURE J. M. Johnson M.D.		PHYSICIAN'S NAME (Type) J. M. JOHNSON M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-60	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cem.		22d. LOCATION (City, town, or county) (State) Issue, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The HUNTT Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/25/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 11-1-1960 2-23-60 et

CERTIFICATE OF DEATH

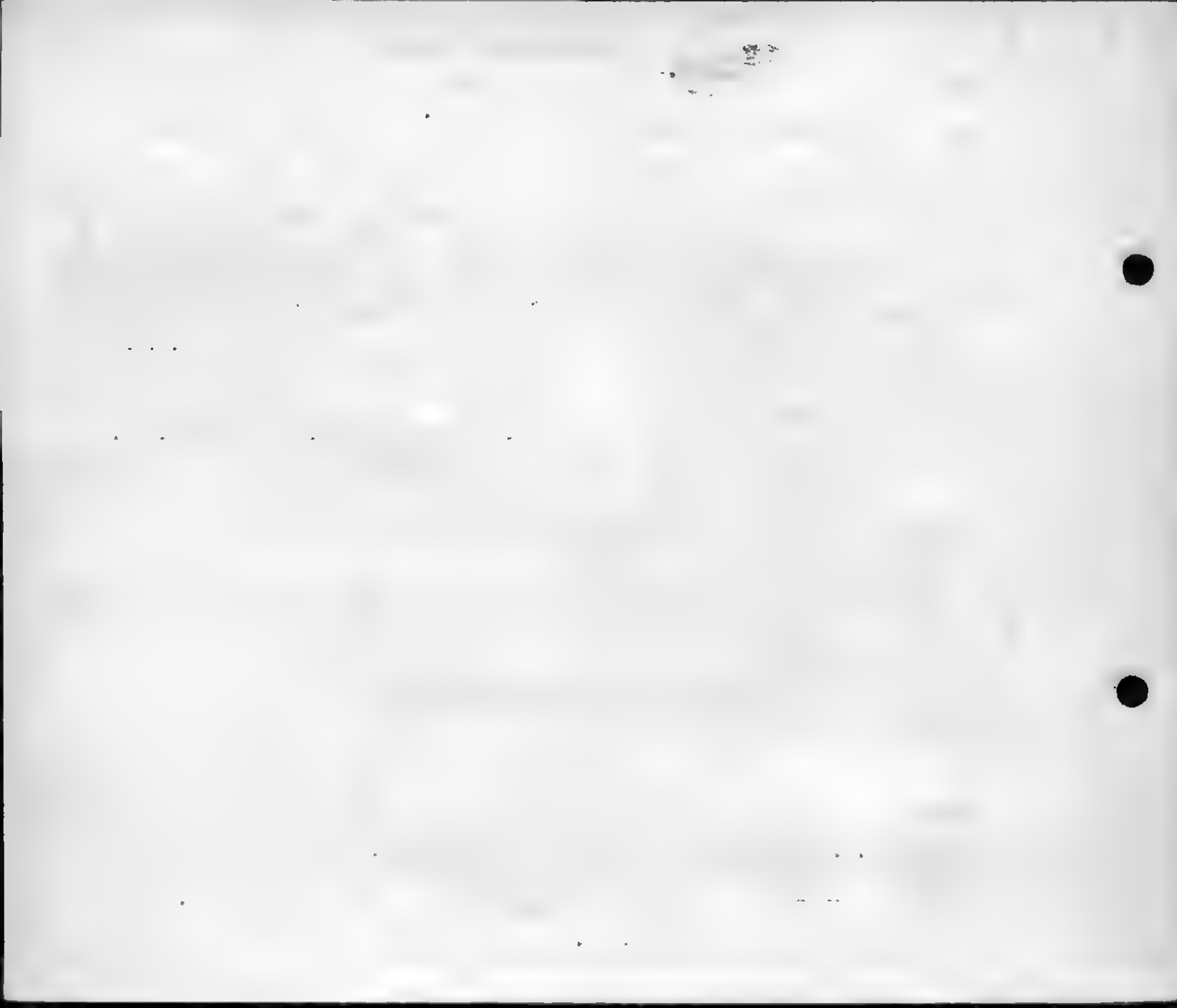
1918

01911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Francis Middle Philip Last Moran				4. DATE OF DEATH Month Feb Day 11 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1888	9. AGE (In years last birthday) 72 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Moran				14. MOTHER'S M maiden NAME Alice Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. Marianna Canter, Hughesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). 443X DUE TO Coronary Artery Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension DUE TO (b). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Diabetes DUE TO (c). Chronic Kidney Disease							INTERVAL BETWEEN ONSET AND DEATH 2-10-60 1950
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1950 to 2-11 , 19 60 , that I last saw the deceased alive on 2-11 , 19 60 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 2-12-60							
ACTUAL SIGNATURE E. J. Eelen		M.D. La Plata, Maryland					
PHYSICIAN'S NAME (Type) E. J. Eelen, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-60	22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	22d. LOCATION (City, town, or county) (State) Bryantown Md.				
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.			24a. REC'D BY REGISTRAR DATE FEB 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

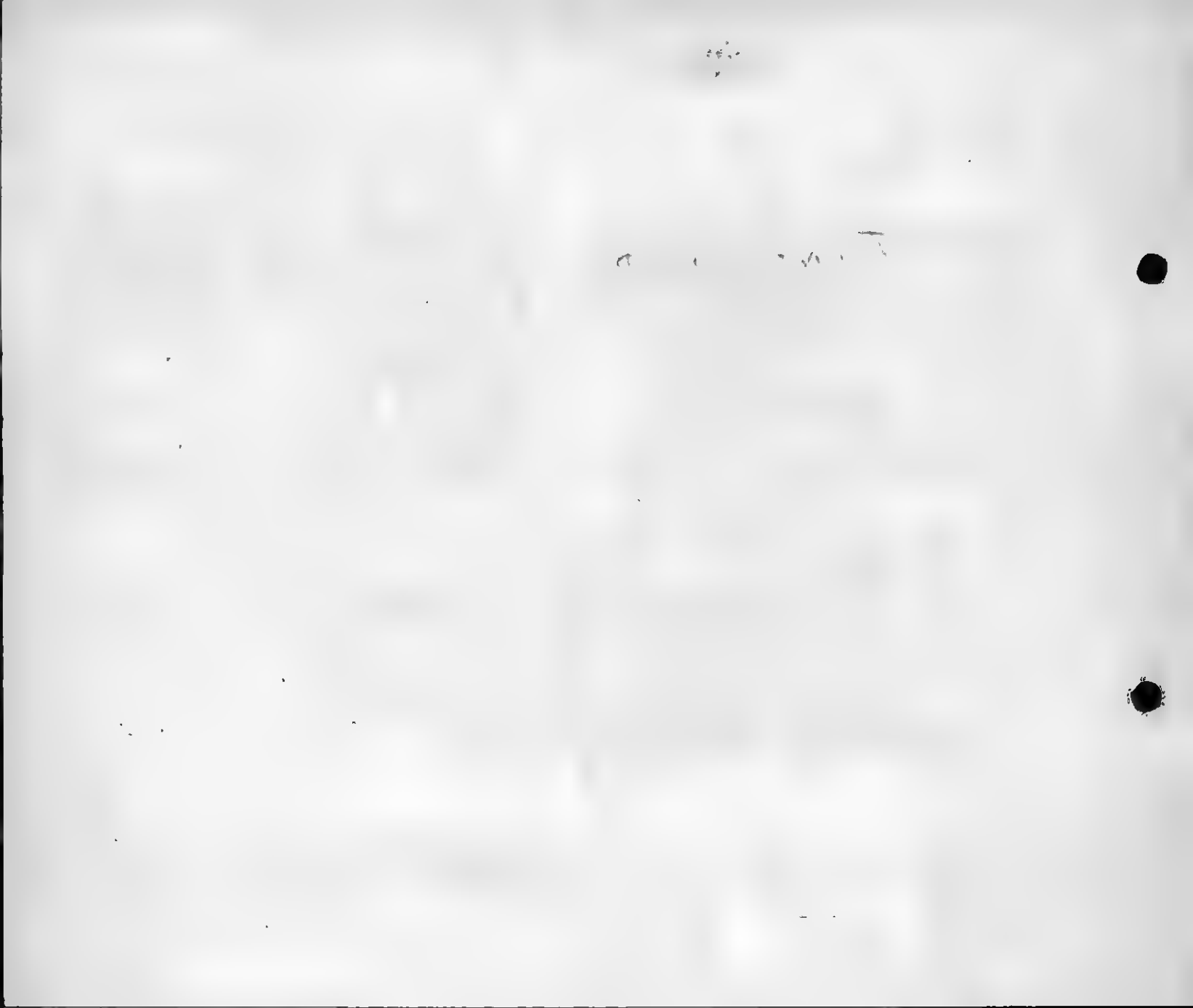
Reg. Dist. No.

01912

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Waldorf c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution. Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS Rt 1 Box 44 e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Richard Moreland First Middle Last 4. DATE OF DEATH FEBRUARY 8 1960 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Jan 5, 1958 9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Moreland 14. MOTHER'S MAIDEN NAME Helen Irene	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Helen Irene Moreland, Waldorf, Md. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Skull Fracture DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto accident - Rt. 382 20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 2-8-60 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Waldorf (County) Charles (State) Md.		-car went off road and struck tree; child went thru windshield	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V.B. Detto EXAMINER'S NAME (Type) V.B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/8/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-10-60	22c. NAME OF CEMETERY OR CREMATORY St Peters	22d. LOCATION (City, town, or county) (State) Waldorf, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland ADDRESS		24a. RECEIVED BY REGISTRAR 12 12 60 DATE	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1920

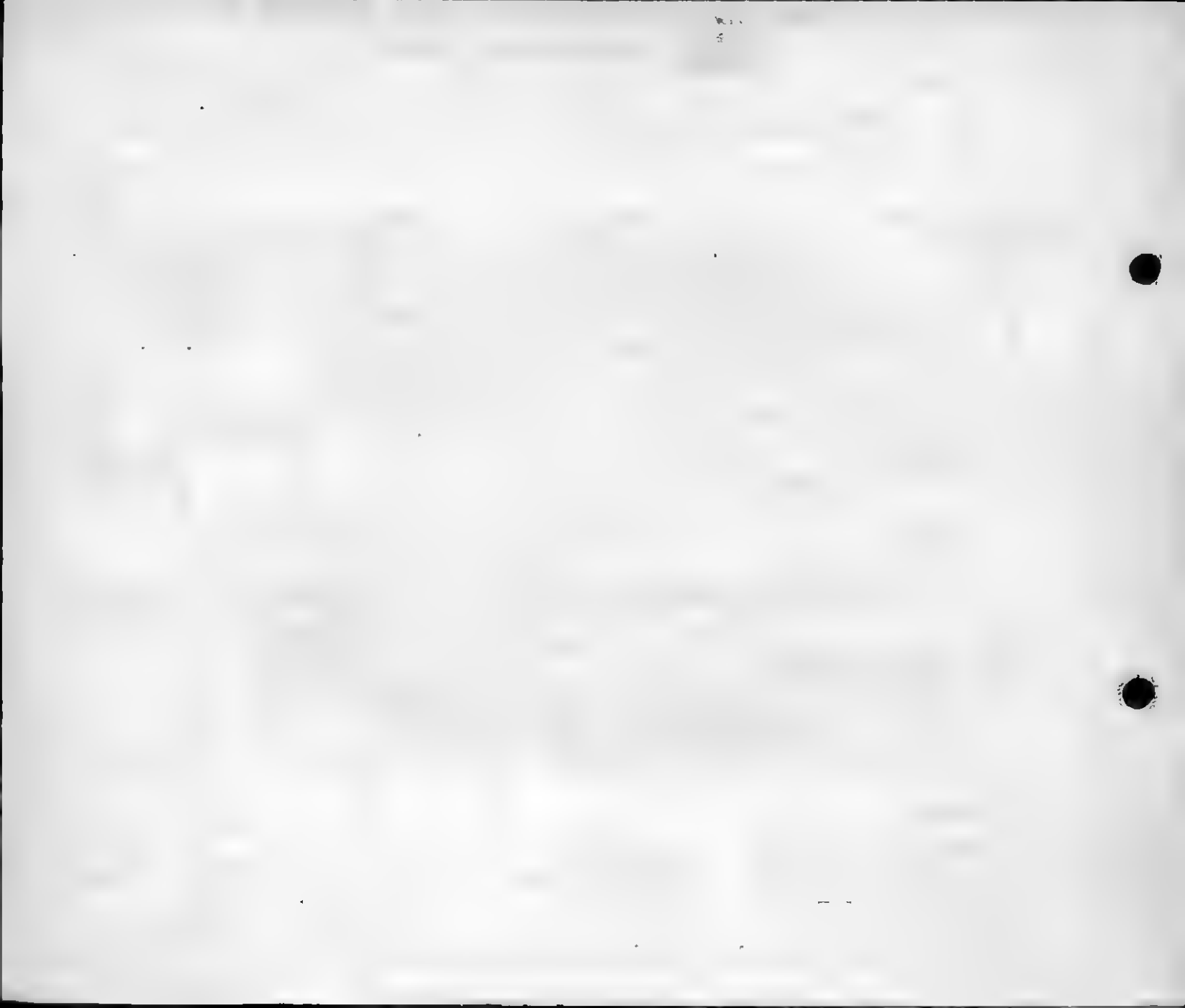
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomfret		c. LENGTH OF STAY IN 1b Unk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomfret	
3. NAME OF DECEASED (Type or print) First CAROLINE Middle V. Last PROCTOR		4. DATE OF DEATH Month Feb Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8, 1876
9. AGE (In years less birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustine Butler		14. MOTHER'S MAIDEN NAME Elizabeth Ann Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Lee Proctor, Pomfret, Maryland		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-1957 to 2-4-1960 , that I last saw the deceased alive on 1-20-60 , 19____, and that death occurred at 6-4 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. M. Johnson M.D.		ADDRESS (Street, city or town, state) The Plaza, Md. DATE SIGNED 2-6-60	
PHYSICIAN'S NAME (Type) F. M. JOHNSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-9-60	22c. NAME OF CEMETERY OR CREMATORY St Josephs	22d. LOCATION (City, town or county) (State) Pomfret, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01914

1921

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <u>Maryland</u> b COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbury</u>	c. LENGTH OF STAY IN 1b <u>29 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harbury</u>		d STREET ADDRESS <u>Harbury</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Spencer</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-78</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church of God</u>	
11. BIRTHPLACE (State or foreign country) <u>Gazoo County, Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jefferson Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Caldwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16 1995</u>	
17. INFORMANT <u>Mrs John S. Reynolds</u>		Address <u>Harbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>2/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>60</u> , and that death occurred at <u>1220</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Pusey</u>		M.D. <u>5 Indian Head Ave</u> DATE SIGNED <u>2/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		<u>Indian Head, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/6/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Paro Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

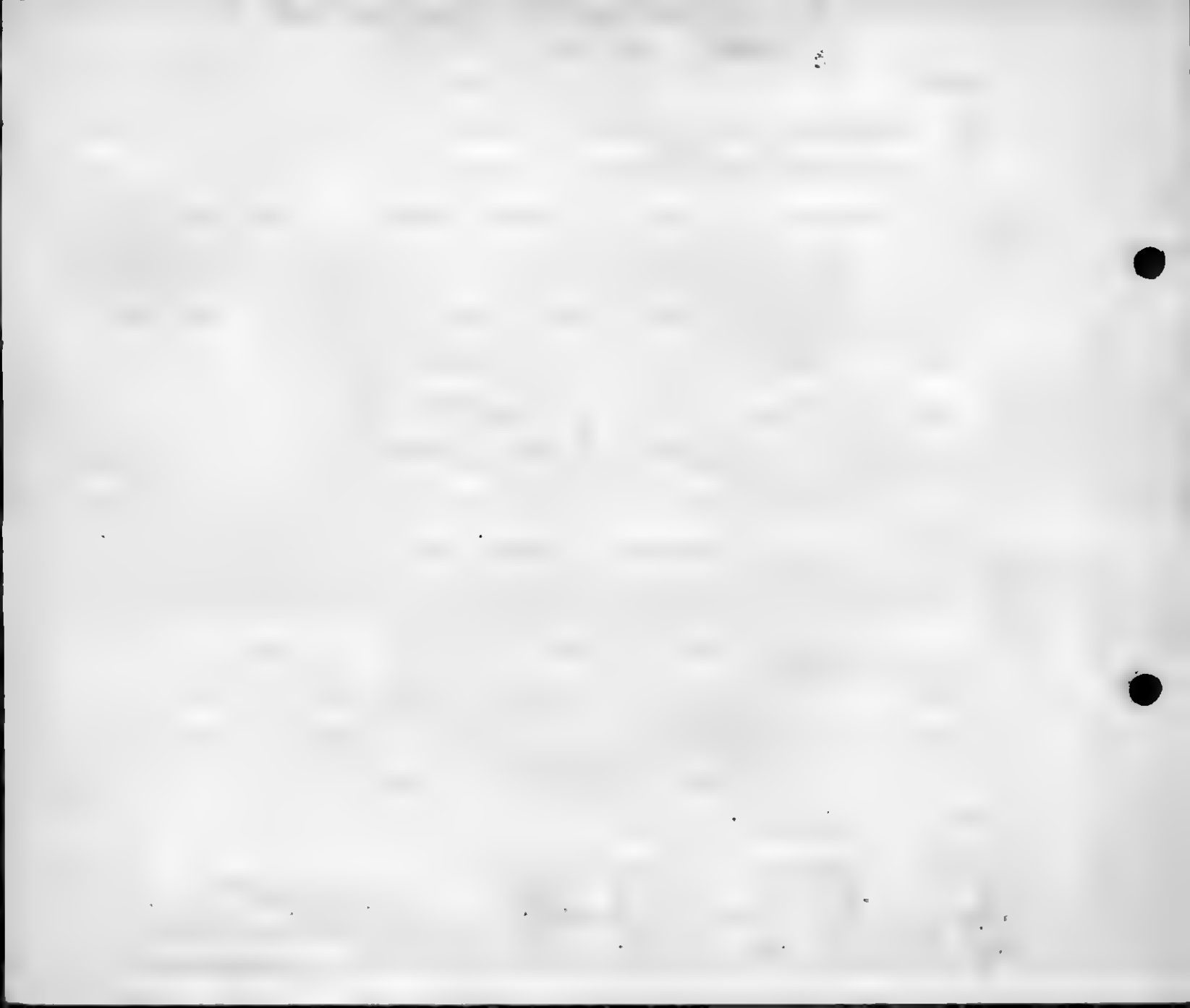
1922

CERTIFICATE OF DEATH

Reg. Dist. No.

01915

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE BLANCHE ROBEY</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Frank Henkelain</u>				14. MOTHER'S MAIDEN NAME <u>Jane Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Samuel Robin Walden (Husband)</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO (b) <u>Chronic Myocardial Disease</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>_____</u> a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 26, 1959</u> to <u>Feb 1, 1960</u> , that I last saw the deceased alive on <u>Jan 30, 1960</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert M. Seem</u> M.D.				DATE SIGNED <u>2/1/60</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT M SEEM MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 3 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) <u>Pomfret, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heath Funeral Home, Waldorf, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Tuma</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
<div style="display: flex; justify-content: space-between;"> <div> <p>Items 18&21 Film 259 2-10-60</p> <p>1923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> <p>Items 7, 11, 12, 13, 14 2-29-60 et</p> </div> <div>01916</div> </div>									
1. PLACE OF DEATH a. COUNTY Charles					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grayton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grayton				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Grayton					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) IDA			First IDA Middle SANDERS Last SANDERS			4. DATE OF DEATH Month February Day 15 Year 1960		9. AGE (In years less birthday) 51 yrs	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Grayton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Guthrie					14. MOTHER'S MAIDEN NAME Annie Shivers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheobronchitis									
501X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO									
(c)									
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a.									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE R S Fisher					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED 2/17/60				
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF 2-20-60		22c. NAME OF CEMETERY OR CREMATORY Grayton		22d. LOCATION (City, town, or country) (State) Grayton Md		
23. FUNERAL DIRECTOR W N Bacon					ADDRESS 1722 74 St NW		24a. REC'D BY REGISTRAR FEB 23 '60		
							24b. REGISTRAR'S SIGNATURE C. S. Fisher		

521

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18&21 Film 258
3-10-60 ams
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH 1924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 11, 12, 13, 14, 15, 16, 17, 20, 29-60 of

1. PLACE OF DEATH
a. COUNTY **Charles** b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Grayton** c. LENGTH OF STAY IN 1b **MARYLAND** d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Grayton**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Charles** c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Grayton** d. STREET ADDRESS **1** e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)
First **JOSEPHINE** Middle **SAN** Last **DERS** 4. DATE DEATH **February 15 1960** Month **February** Day **15** Year **1960**

5. SEX **Female** 6. COLOR OR RACE **Colored** 7. MARRIED ☐ NEVER MARRIED ☒ B. DATE OF BIRTH **70** yrs. 9. AGE (In years last birthday) **70** yrs. IF UNDER 1 YEAR: Months **70** Days **0** Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Grayton, Maryland** 10b. KIND OF BUSINESS OR INDUSTRY **Grayton, Maryland** 11. BIRTHPLACE (State or foreign country) **U.S.A.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **John Wesley** 14. MOTHER'S MAIDEN NAME **Sarah Montgomery**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **16. SOCIAL SECURITY NO.** **17. INFORMANT** Address **Grayton, Maryland**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Bilateral bronchopneumonia**
491X DUE TO
Conditions, if any, which gave rise to immediate cause (b) **491X**
(a), stating the underlying cause last. DUE TO (c) **491X**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) **19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **20f. (City or town) (County) (State)**

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

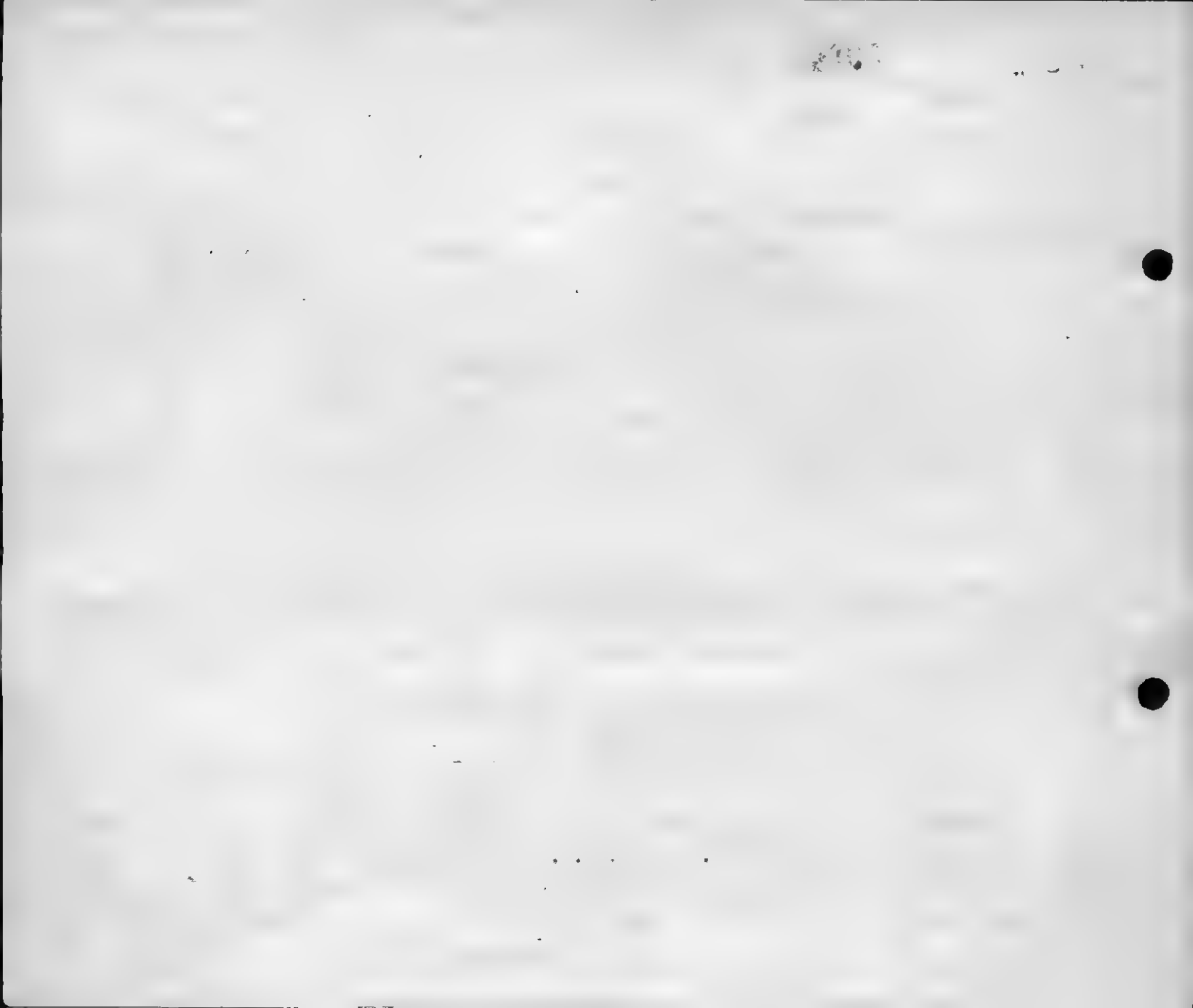
CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **Russell S. Fisher, M.D.** DATE SIGNED **2/17/60**

EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** Address (Street, city, town, or county) **Grayton, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **2-20-60** 22c. NAME OF CEMETERY OR CREMATORY **Church** 22d. LOCATION (City, town, or county) (State) **Grayton, Md.**

23. FUNERAL DIRECTOR **W. H. Bacon** ADDRESS **1722 1/2 St. N.W.** 24a. REC'D BY REGISTRAR **FEB 23 '60** 24b. REGISTRAR'S SIGNATURE **Carl A. S. Fisher**



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

18&21 Film 258
15-10-63 ans

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Items 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH
a. COUNTY **Charles** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY (in days)
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Grayton

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE **Maryland** b. COUNTY **Charles**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Grayton
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)
First **ROBERT** Middle Last **SANDERS**
4. DATE OF DEATH Month **February** Day **15** Year **1960**

5. SEX **Male** 6. COLOR OR RACE **Colored** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
9. AGE (In years last birthday) **65** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)
Grayton, Maryland
12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME **John Wesley** 14. MOTHER'S MAIDEN NAME **Sarah Montgomery**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arteriosclerotic cardiovascular disease**
+22.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

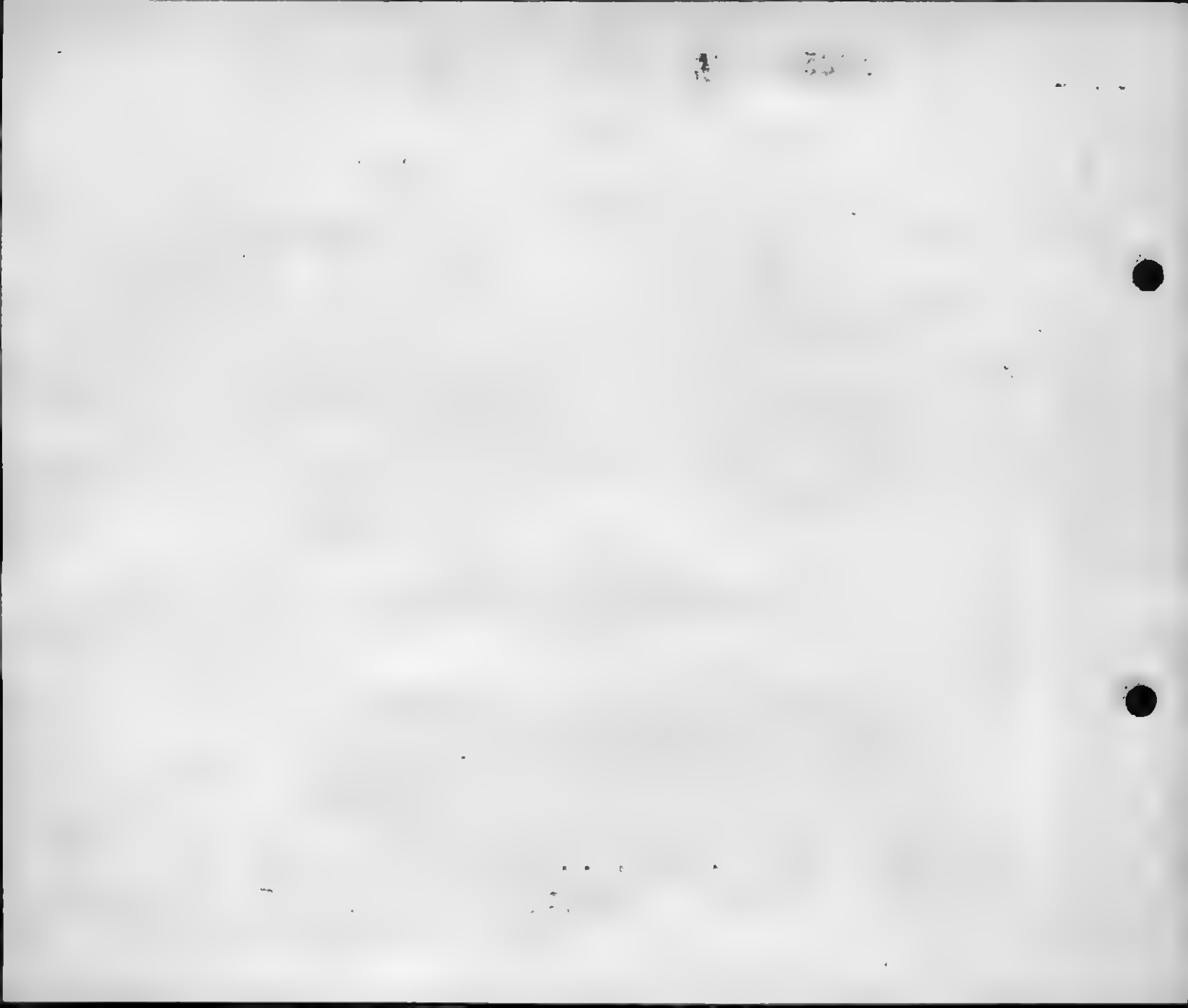
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **R. S. Fisher** M.D. CHIEF MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **2/17/60**
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, or other disposal (Specify) 22b. DATE THEREOF **2-20-60** 22c. NAME OF CEMETERY OR CREMATORY **Grayton** 22d. LOCATION (City, town, or county) (State)
Grayton, Md

23. FUNERAL DIRECTOR **W. H. Bacon** ADDRESS **1722 7th St NW** 24a. REC'D BY REGISTRAR **FEB 23 '60** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kneib**



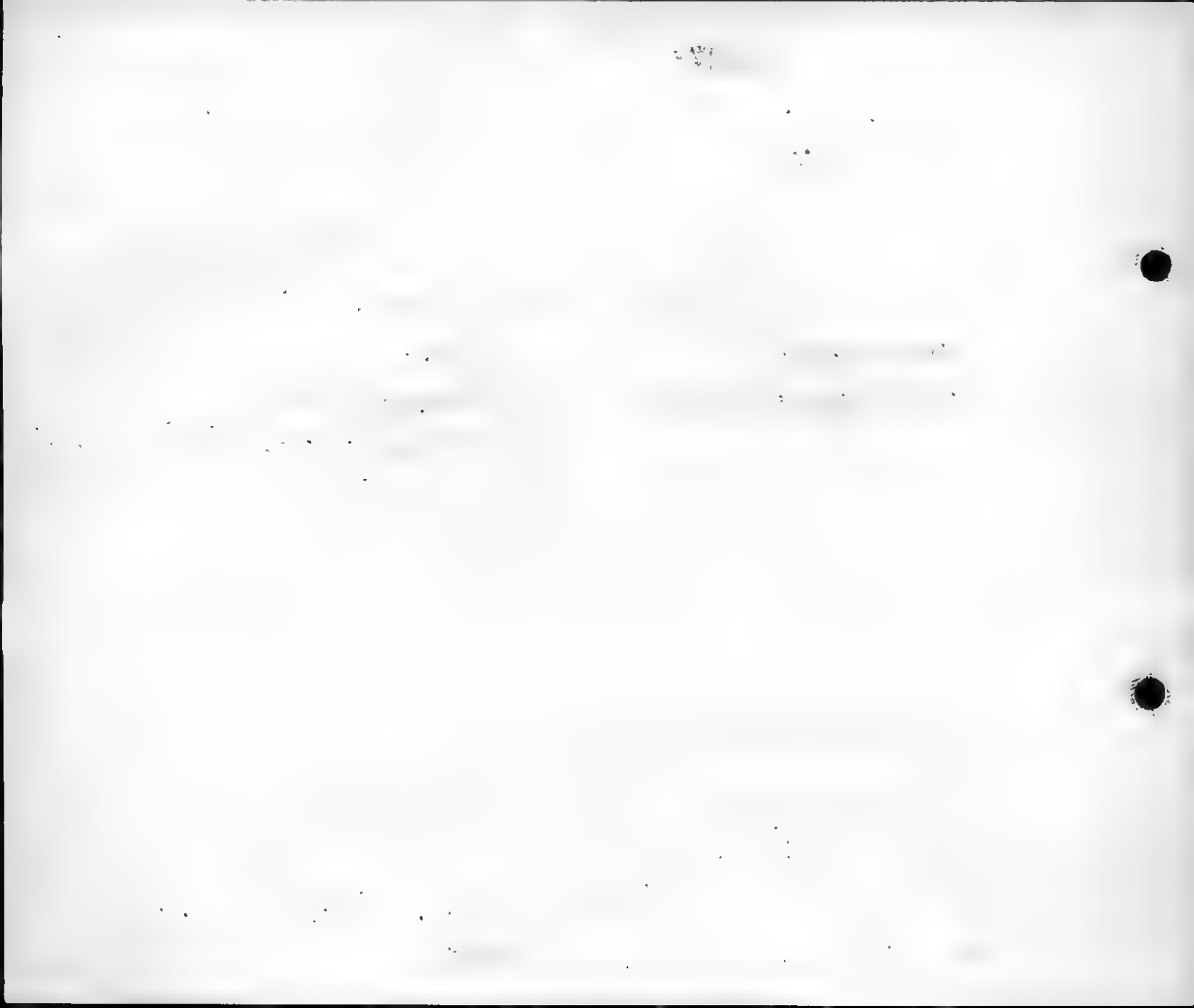
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 2-23-60 et
1926 CERTIFICATE OF DEATH

Reg. Dist. No. 01913

1. PLACE OF DEATH a. COUNTY <i>Charles</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Mem. Hospital</i>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>DELLA</i> Middle <i>SAVOY</i> Last <i>SAVOY</i>		4. DATE OF DEATH Month <i>FEB</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1876</i>
9. AGE (In years last birthday) <i>83</i> yrs		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Brown</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ives</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>INFORMANT</i> Address <i>Sarah Johnson LaPlata, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>455X</i> DUE TO <i>Sansone of left foot</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO <i>3 weeks</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> m. <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1958</i> to <i>2-12</i> , 1960 that I last saw the deceased alive on <i>2-12</i> , 1960, and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>2-12-60</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 15 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Catharine Cem</i>	22d. LOCATION (City, town, or county) (State) <i>La Plata, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i> ADDRESS <i>Waldorf Md</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 18 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1927 CERTIFICATE OF DEATH

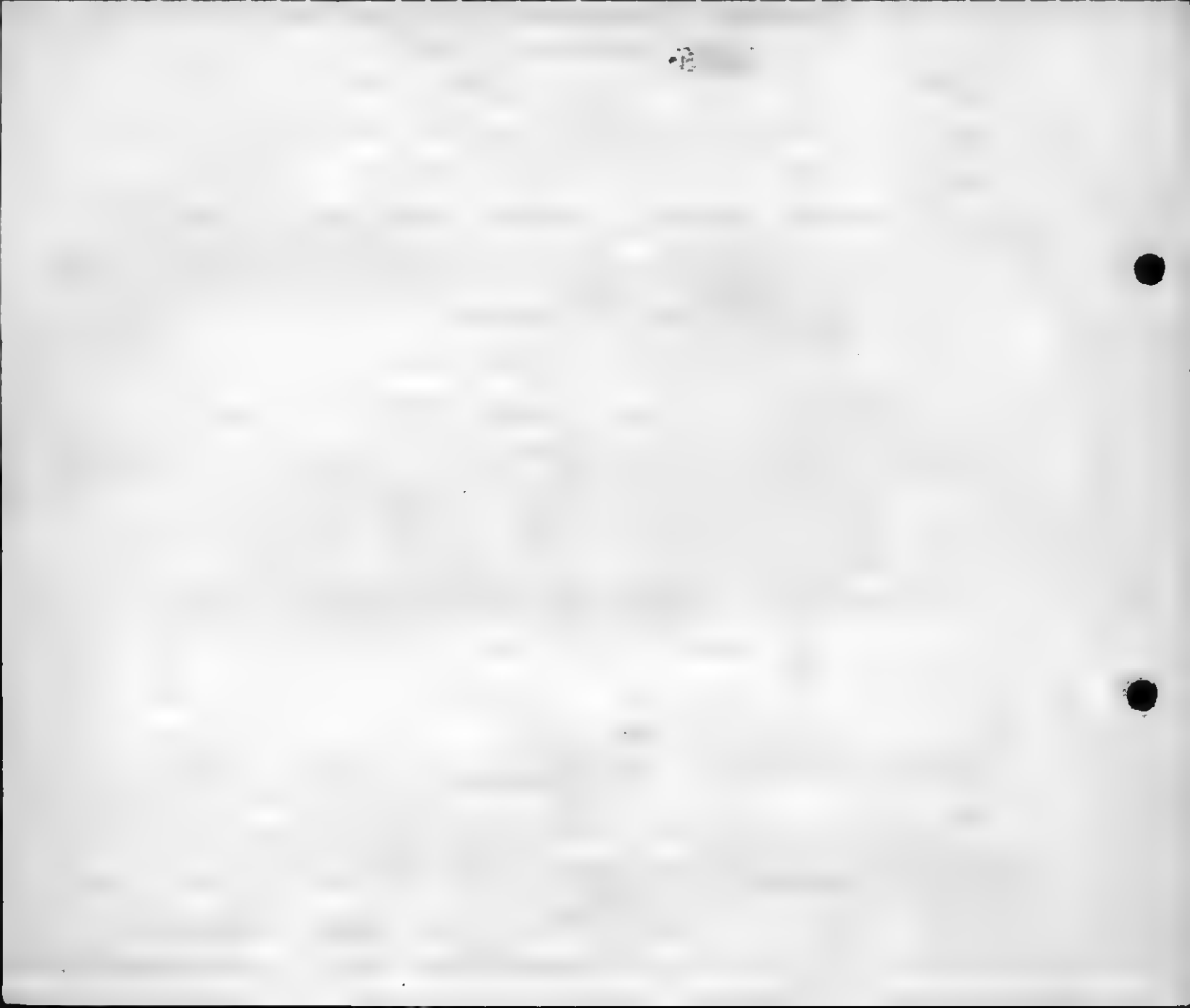
Reg. Dist. No.

01920

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Shlagel</u> Last <u>Shlagel</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 19 1888</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Charles W. Shlagel, Waldorf, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Pneumonia</u> DUE TO (c) <u>Chronic Myocardial Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>59</u> , to <u>Feb 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. M. Seron MD</u> M.D.				ADDRESS (Street, city or town, state) <u>Agassiz, Md.</u> DATE SIGNED <u>2/1/60</u>			
PHYSICIAN'S NAME (Type) <u>V. M. SERON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE R 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01921

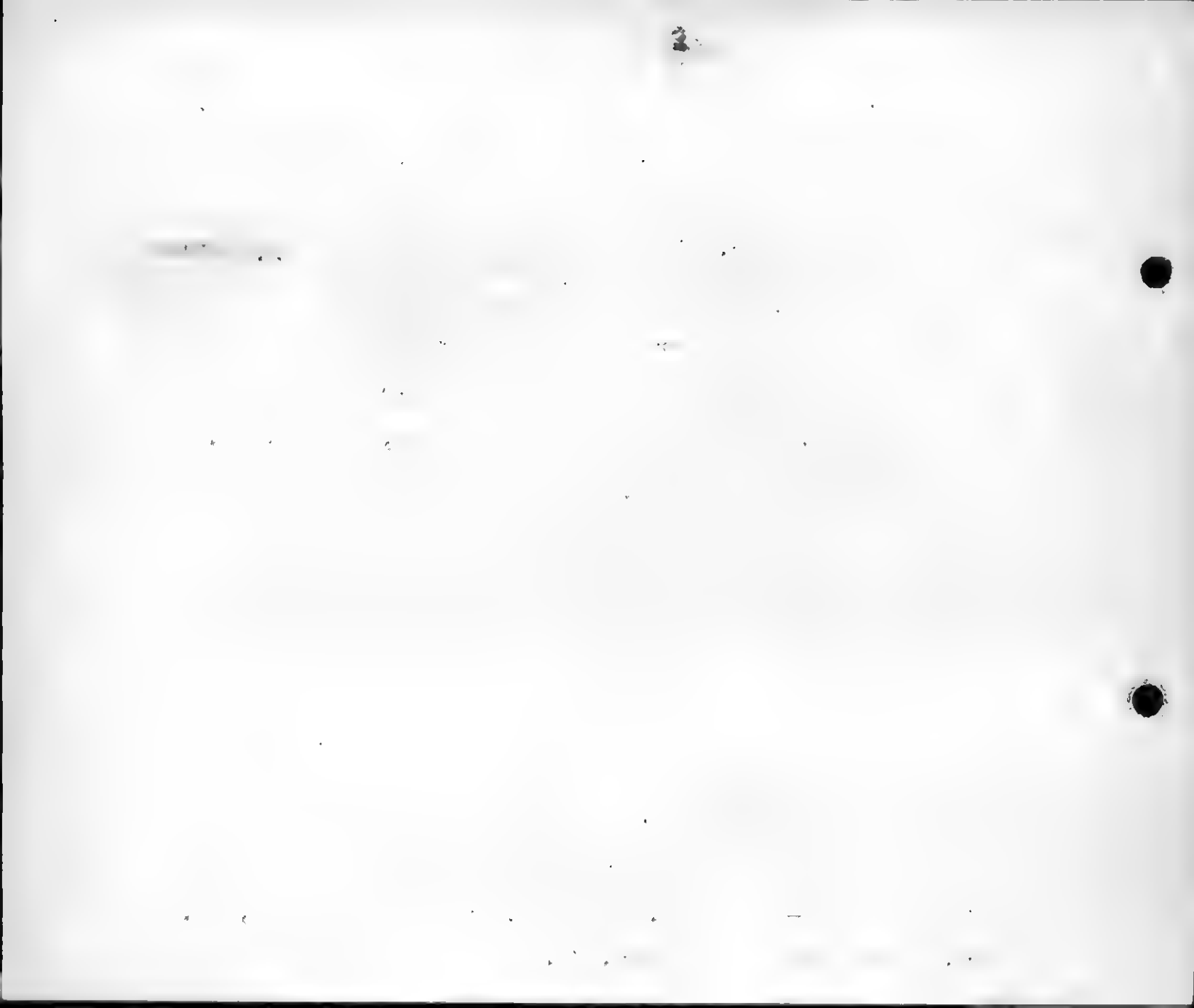
1928 - CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> c. LENGTH OF STAY IN lb <u>Life</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> d. STREET ADDRESS <u>1</u>															
3. NAME OF DECEASED (Type or print) <u>David A. Tolson</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1960</u>															
5 SEX <u>M</u>		6 COLOR OR RACE <u>Colored</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Sept 26 1959</u>		9. AGE (In years last birthday) <u>5</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Costa</u>						14. MOTHER'S MAIDEN NAME <u>Frances Tolson</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>				INFORMANT <u>Frances Tolson, Waldorf, Md.</u>				Address <u></u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492X</u> DUE TO <u>Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Viral Pneumonia</u> (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>22</u> <u>8</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>														19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>															
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>				20f (City or town) (County) (State) <u></u>							
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>60</u> , to <u>2-14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>60</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.																			
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D. <u>Bradley, Md.</u>																			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson, M.D. - Bradley, Md.</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-16-60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>						ADDRESS <u>Waldorf, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

4-00213XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



01922

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived; if institution; Residence before admission) a. STATE		Maryland b. COUNTY		Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Marbury		Life		X Marbury							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			Thomas Joseph Wright			Feb			2 1960		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White			August 15, 1870		89		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Retired		U.S. Govt		Maryland				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Richard Wright				Sallie Barker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		Sp. Amer. War		NONE		Mrs. Theodore DeLozier, Marbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								INTERVAL BETWEEN ONSET AND DEATH			
Coronary arteriosclerosis								2 yrs			
(b) DUE TO											
General arteriosclerosis								yrs			
(c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I attended the deceased from June 13th, 1956, to February 21, 1960 that I last saw the deceased alive on Feb. 2nd, 1960, and that death occurred at 4:20A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE		Paul Chen, M.D.		M.D. Accokeek, Md.		2-3-60					
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
Burial		2-4-60		Arlington National		Arlington, Va.					
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
The Hunt Funeral Home, Waldorf, Maryland						FEB 8 '60		Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1920 CERTIFICATE OF DEATH

County of _____

City of _____

State of _____

Dec. 27

1920

Male

John

Smith

White

Age

45

Years

Married

Occupation

Teacher

at

Public School

Address

123

St.

Baltimore

Cause of Death

Heart

Disease

of

the

Coronary

Artery

Obstructed

by

atherosclerosis

and

hypertension

of

the

heart

caused

death

on

Dec. 27

1920

at

home

of

deceased

person

John

Smith

White

Age

45

Years

Married

Occupation

Teacher

at

Public School

Address

123

St.

Baltimore

Cause of Death

Heart

Disease

of

the

Coronary

Artery

Obstructed

by

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing it and "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret Rural</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pomfret, rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>KEVIN JUAN YATES</u>			4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-29</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>11</u> Days <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>THOMAS YATES</u>			14. MOTHER'S MAIDEN NAME <u>DOROTHY TAYLOR</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dorothy Elaine Yates, Pomfret, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lung cancer</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Had some cold - prob</u> DUE TO (c) <u>pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2-16-60</u> <u>2-15-60</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-17-60</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>Pomfret Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

4000 365XV4

